DOCUMENT RESUME

ED 227 063 SP 021 762

AUTHOR Smith, Margaret M.
TITLE Who Teaches Health? Current Issues.
INSTITUTION ERIC Clearinghouse on Teacher Education, Washington, D.C.
SPONS AGENCY National Inst. of Education (ED), Washington, DC.
PUB DATE Feb 83
CONTRACT 400-78-0017
NOTE 61p.
AVAILABLE FROM ERIC Clearinghouse on Teacher Education, One Dupont Circle, Suite 610, N.W., Washington, DC 20036 ($4.50).
PUB TYPE Viewpoints (120) -- Information Analyses - ERIC Information Analysis Products (071)

EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS *Educational Needs; *Educational Quality; Elementary Secondary Education; Futures (of Society); *Health Education; Professional Associations; State Standards; *Teacher Background; Teacher Certification; Teacher Qualifications

ABSTRACT

This publication, offering support for the preservation and implementation of comprehensive school health education programs: (1) determines what comprehensive school health education should be; (2) describes the skills and knowledge that should be required of health educators; and (3) recommends methods for providing effective health education at the elementary and secondary school levels. The first two sections, on health, health education, and comprehensive school health education, offer definitions on the purposes, content, and status of health education. The following two sections investigate who teaches health education in the public schools, and their qualifications, characteristics, certification, and background. The fifth section, on the ideal state of health education, offers four recommendations concerning the preparation of all school personnel and of health educators. Strategies for enhancing teacher preparation, at the national, state, and local levels, are discussed in the sixth section. A list of 115 references is attached. Appendices include statements, from the American Academy of Pediatrics, the National Parent-Teacher Association, the Education Commission of the States, and the Association for the Advancement of Health Education, concerning comprehensive school health education and teacher certification for health education. (CJ)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

Who Teaches Health?

by Margaret M. Smith

ED227063

Current Issues

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

SP 021 762

ERIC

WHO TEACHES HEALTH?

by Margaret M. Smith
Oregon State University

ERIC Clearinghouse on Teacher Education
American Association of Colleges for Teacher Education
One Dupont Circle, Suite 610, Washington, D.C. 20036

February 1983 Clearinghouse No. SP 021 762

This and other publications may be ordered from the ERIC Clearinghouse on Teacher Education. A list is available on request from the Clearinghouse.

The ERIC Clearinghouse on Teacher Education is funded by the National Institute of Education. The material in this publication was prepared pursuant to contract number 400-78-0017 with the National Institute of Education, U.S. Department of Education. Contractors undertaking such projects under government sponsorship are encouraged to express freely their judgments in professional and technical matters. Prior to publication, the manuscript was submitted to external referees for critical review and determination of professional competence. This publication has met such standards. However, points of view or opinions do not necessarily represent the official views or opinions of the National Institute of Education, the Clearinghouse, or the contracting agent, the American Association of Colleges for Teacher Education.

Printed in the United States of America.

Library of Congress Catalog Card No.: 83-80306

CONTENTS

FOREWORD v

WHO TEACHES HEALTH? 1

Health and Health Education 1
Comprehensive School Health Education . . . 3
Everyone Teaches Health 7
Health Educators 12
The Ideal State of Health Education . . . 17
Strategies for Enhancing Teacher Preparation . . . 22
Summary 25

REFERENCES 26

APPENDIX A 36

APPENDIX B 46

APPENDIX C 51

FOREWORD

Our society places increasing emphasis on the promotion of health and wellness. Numerous studies have identified knowledge and skills in health education that relate directly to the efficient, effective functioning of the human being.

Our nation's schools must offer quality health education in order to provide students with the necessary understanding and motivation to live productive, healthy lives. The quality of school health education is often determined by the interest and professional preparation of teachers. Qualifications of health educators vary from state to state, and although most state legislators support the need for a comprehensive school health curriculum, they often do not allocate the financial resources needed to implement these programs.

This publication from the ERIC Clearinghouse on Teacher Education offers support for the preservation and implementation of school health education programs. The author focuses on determining what comprehensive school health education should be, describing the skills and knowledge that should be required of health educators, and recommending methods for providing quality health education for our children.

The Clearinghouse acknowledges with appreciation this professional contribution of Dr. Margaret Smith. Dr. Smith is assistant professor of health at Oregon State University, Corvallis. Thanks also go to the content reviewers, whose suggestions were useful in the preparation of the final manuscript.

LAURIE PRIEST
Associate for HPERD
ERIC Clearinghouse on
Teacher Education

WHO TEACHES HEALTH?

A great deal has been written about health in public schools. Not a year goes by without passage of recommendations on how to improve its teaching in our nation's classrooms. Yet what is long overdue is actual implementation of many of these goals and recommendations. This work addresses not only the nation's need for putting a plan into action, but, more importantly, the need to work aggressively toward improving both student health and health curricula in schools. The parties responsible for seeing that these goals are achieved include teachers, health educators, and the millions of people who support education in America today.

Health and Health Education

What is health and what is health education? Over time, health and health education have been defined in many ways. One of the better examinations of these definitions may be found in the journal Health Education, which devoted the entire issue of January-February 1978 to the question. We have grappled with these questions for centuries. Comparing definitions offered by professionals and students provides us with some interesting insights into both.

From professionals, we get the picture that health is:

- to be sought not as an end in itself but as a means to the good life, a concept posited by the philosopher Plato (Cousins 1978);
- a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organization 1947, p. 3);

- o a quality of life involving dynamic interaction and interdependence among the individual's physical well-being, his mental and emotional reactions, and the social complex in which he exists (1967);
- o an elusive term which usually encompasses the notion of individual and collective well-being with physical, social, and psychological dimensions (U.S. Department of Health and Human Services, Bureau of Health Education, 1980).

From students, we hear health defined as:

- o total fitness--physical, mental, emotional, spiritual, and social;
- o breathing, happiness, feeling good about oneself;
- o holistic wellness;
- o a state of being invigorated, in constant change, and hopefully positive;
- o the process of taking care of oneself and being aware of one's environment;

From professionals come definitions of <u>health education</u> as:

- o a process with intellectual, psychological, and social dimensions relating to activities that increases the abilities of people to make informed decisions affecting their personal, family, and community well-being (Society of Public Health Education 1973, p. 33);
- o the process of assisting individuals, acting separately and collectively, to make informed decisions about matters affecting individual, family, and community health. Based upon scientific foundations, health education is a field of interest, a discipline, and a profession (U.S. Department of Health and Human Services, Bureau of Health Education, 1980).

From students come characterizations of health education as:

- o learning how to make the most of who you are;
- o making self-care the most important part of life;
- o learning what makes a person tick;
- o a way of learning the skills to be responsible and self-sufficient;
- o a topic of importance for future generations;
- o a favorite classroom course of study.

From these samples it is clear that health encompasses many interrelated facets of human functioning. Yet it is apparent that the term health can be defined in a multitude of ways which provide meaning to individuals. Health education, then, is a means or vehicle that enables individuals to voluntarily adopt behaviors that promote physical and mental well-being.

Comprehensive School Health Education

Health has traditionally been considered an education basic. Although the relationship between health and education has a long history, the strongest support for including health in public school curricula was stated in the National Education Association's Seven Cardinal Principles of Secondary Education in 1918. Of the seven principles, health was listed as the top priority. Again in 1977, national education leaders attending the Winsgpread Conference, whose purpose it was to examine the state of basic skills in American education, reaffirmed health as a basic (Brodinsky 1977). Today health is viewed as a curriculum "basic" by an ever-increasing number of states (Association for the Advancement of Health Education 1982, pp. 1, 4). This view is largely a result of the national educational trend toward emphasis on curricular accountability in public education.

We pose another thesis of particular importance. Health is more than an education basic--health is the foundation of the education process. Let us briefly explore the rationale behind this view.

The basic goal of education in America has been to develop functional citizens capable of contributing to society. In recent years this vision of the functional citizen has been expanded to include the wide variety of life roles which adults assume. Schools have been charged with the responsibility to develop the skills, knowledge, and attitudes needed to perform in such roles as, for example, parents and consumers. As such, schools should provide opportunities for future adults to develop competence in life roles. In order for future adults to function competently in life roles, it is essential for them to acquire knowledge of health and coping skills.

The number of personal health decisions--decisions concerning health behaviors, health risks, and illness prevention--made daily by adults is tremendous. Functional adults make these decisions with relative ease. Therefore, by first defining what it means to be a functional, competent adult, educators can design programs for transmitting the complex information, skills, and attitudes required to become a healthy adult capable of performing many life roles.

Educators have historically accepted the fact that promoting good health is an important aim of schools. As Sue Carson stated,

> There is no question that the primary mission of the public school is the education of our children, nor is there any question that the health of school-age children is a primary factor affecting their ability to learn in school. (1981, pp. 573-4)

Quite simply, unhealthy children cannot learn readily. For example, a child who comes to school without an adequate breakfast may experience a rapid drop in blood sugar that reduces his or her ability to concentrate.

Since learning about health has direct application to both a student's future (learning how to adopt a healthy lifestyle helps students move toward healthy adult life roles) and present (knowing how to stay healthy increases students' capacities to learn), it is clear that health education should take place in sequential steps over a long period of time. Comprehensive school health

education programs are the major means for accomplishing this objective.

It is essential at this point to define the components of comprehensive school health education. These are health information, health instruction, and health education. Health information involves the dispensing of accurate and factual information about health. Students frequently get information about health through media--hall posters, school newspapers, and classroom handouts. Health instruction, on the other hand, is an avenue by which health information is disseminated as well as a forum for examining health attitudes, skills, and behaviors. Health education is the "process of assisting, acting separately and collectively to make informed decisions about matters affecting individual, family and community health" (U.S. Department of Health and Human Services, Bureau of Health Education 1980, p. 6). Each of these elements contributes to the next, but each becomes more complex in nature.

A comprehensive school health education merges all three--health information, health instruction, and health education. It requires that each of these elements be built sequentially. Recognizing that these elements build on one another is an important concept to a unified school health education plan.

Sequential health education, however, should not be the only consideration. A great deal of the professional literature in the last ten years has dealt with comprehensive school health education (see references). The concept has clearly been supported by educators and continues to be supported by professional organizations throughout the nation (see Appendix A).

What the literature also demonstrates is the need for a means to put this plan into action. The School Health Education Project staff has devised a clear comprehensive school health education model based on an operational definition that includes five points: goals and objectives, content, resources, evaluation, and management. The complete operational definition of comprehensive school health education is in Appendix B.

It can be looked at from two viewpoints (see Table 1). It appears that the content areas, as suggested by the School Health Education Project, have shifted from a

Table 1
Comprehensive Health Education

Content Recommended by Education Commission of the States Task Force*	Content Recommended by School Health Education Project**
Personal health	Smoking
Mental and emotional health	Nutrition
Prevention and control of disease	Alcohol abuse
Nutrition	Driving (safety)
Substance use and abuse	Exercise
Accident prevention and safety	Human sexuality and contraceptive use
Community health	Family development
Consumer health	Risk management
Environmental health	Stress management/ coping/enhanced self esteem
Family life education	

* Examples not all inclusive. SOURCE: Education Commission of the States. Recommendations for School Health Education: A Handbook for State Policy Makers. Report No. 130 (Denver: Education Improvement Center, March, 1981).

**Including but not limited to these examples. SOURCE: Association for the Advancement of Health Education. "Comprehensive School Health Education: An Operational Definition," HE-EXTRA 5, 1 (Fall 1982): 1 and 4.

global, community health perspective to a more specific, personalized perspective. That is, there has been a movement toward focusing on health risk and/or health-promoting behavior of the individual.

This shift in focus is in step with both the Surgeon General's report, Healthy People (U.S. Department of Health, Education, and Welfare, Public Health Service 1979) and Objectives of a Nation (U.S. Department of Health and Human Services, Public Health Service 1980), as reported by the Department of Health and Human Services. These documents were intended to lay out contemporary national health goals and spell out specific objectives designed to meet these goals. In keeping with this shift in focus from community to personal health, conferees at the National Conference for Institutions Preparing Health Educators in Birmingham, Alabama, in February 1981 suggested that some global, community, or "traditional" topics may need to be dropped while others may need to be added in order to more clearly portray contemporary health issues. This shift in focus may create problems for individuals charged with the task of teaching health in schools, particularly if their professional preparation was directed exclusively toward global, community health, or "traditional" content areas.

Everyone Teaches Health

In the broadest sense, everyone employed in schools teaches health. This includes not only the classroom teacher or specialist, but also food service staff, administrators, custodians, librarians, and secretaries. They contribute to the teaching of health primarily by example--through the lives they lead. A person's lifestyle is defined by his or her collective behaviors. Thus, all health-related behaviors would define what may be called one's "health lifestyle." Lifestyles are the most significant contributors to health status: The majority of health problems Americans experience are, in large part, influenced by personal lifestyle choices. These lifestyle choices usually include both positive health behaviors (such as stress reduction and regular physical activity) and negative health behaviors (such as

overeating and improper use of prescription medications). But because youths often model adult behavior they see, adults in schools must communicate healthy lifestyles.

Similarly, health can be taught to children by focusing on positive health behaviors that are relevant to their own lives. Attention should be given to reducing health risks as well as to promoting desirable health behaviors. Children can be taught health in many ways. For example:

- o We can teach children positive health behaviors by making healthy snacks available during school breaks. Healthy snacks are whole grains, fruits, and vegetables rather than cinnamon rolls made with refined white flour and lots of sugar.
- o We can teach children about health by bringing the front page of the local newspaper to class to discuss current environmental issues such as the placement of nuclear waste disposal sites and the dangers of building materials like asbestos rather than by memorizing names of the bones in the body.
- o We can teach children about health-related issues such as poverty, inequality, and injustice by creating warm, caring classrooms and school environments in which such issues can be addressed on a personal and local level.

Obviously, some school personnel do a better job than others in teaching health. The most successful are those who "teach what they are" and "teach about what is and can be." That is, they exhibit <u>healthy</u> lifestyles and address issues <u>relevant</u> to their students. This view of the school as a health-laden environment is one that is frequently ignored. The general tendency has been to view health education as a specific course taught within the confines of a classroom. <u>Health</u> is a different academic area. In many respects, health education pervades the total school curricula. Therefore, health education is the responsibility of <u>all</u> school personnel.

Apart from--but not in conflict with--this comprehensive view, there are three specific groups of individuals who are considered to be directly responsible for health instruction in schools. These groups can be

labeled: health teachers, health instructors, and health educators. Each of these groups has an important role in the overall comprehensive school health education program. On a hierarchical basis, each of these groups is presumed to have increasing amounts of health skills and subject area specialization.

Health teachers are those individuals who provide instruction in elementary classrooms throughout the nation. They have been certified by state agencies to teach in grades kindergarten through eight. Due to the nationwide diversity in certification requirements, health teachers frequently have little, if any, preservice health background (Kolacki 1981, pp. 32-4).

Although education codes in 42 states require that health be included as part of the public school curricula, only 22 states include the word health in their certification requirements. (Woellner 1981) In four of these cases, health is listed as an optional requirement. Omitting health from listings of required content areas in certification descriptors clearly demonstrates that colleges and universities offering programs in elementary school teacher preparation need to establish reasonable health education requirements for the nation's future teachers. Failure to see health education as a curriculum priority may be due partly to the fact that the National Council for the Accreditation of Teacher Education (NCATE) evaluation sheet does not include a substandard for health at the elementary level.

A recent publication by the American School Health Association prepared for the U.S. Center for Health Promotion and Education, School Health in America: A Survey of State School Health Programs, provides a clearer picture of the relationship between the educational preparation of elementary teachers and the public schools' expectations of those teachers. (U.S. Department of Health and Human Services, Center for Health Promotion and Education 1981). Data collected for this survey, a joint venture of the American School Health Association and the Education Commission of the States (ECS) in the spring of 1981, has been synthesized and appears in Table 2. The data indicate that although 37 states mandate some type of

Table 2

A Comparison of Elementary Teacher Health Requirements, Expectations, and Support

	Requires Health Ed. Cert. for Elementary Teachers	Mandates Health Topics at the Elem. Level	Provides State Curriculum Guide or Framework
Alabama	varies		x
Alaska	not available		x
Arizona			x
Arkansas	not available	x	
California	x	x	x
Colorado	x	x	
Connecticut	x	x	
Delaware		x	
D.C.	x	x	x
Florida	Health or Phys.Ed.	x	
Georgia	x	x	
Hawaii			x
Idaho		x	x
Illinois	x	x	
Indiana		x	
Iowa	x	x	
Kansas			x
Kentucky	x	x	
Louisiana		Elem. not specified	
Maine	x		
Maryland		x	x
Massachusetts	x	x	
Michigan		x	
Minnesota	not available	x	x
Mississippi		x	x
Missouri			x
Montana	x		
Nebraska	not available	x	x
Nevada			x
New Hampshire		x	x
New Jersey	x	x	x
New Mexico	not available	x	
New York		x	
N. Carolina	x	x	x
North Dakota	x		x
Ohio	x	x	x
Oklahoma		x	
Oregon		x	x
Pennsylvania		x	x
Rhode Island		x	
S. Carolina	x	x	x
South Dakota			
Tennessee	not available	x	
Texas		x	x
Utah	content course must be offered or integrated	x	x
Vermont		proposed	
Virginia			x
Washington		x	
W. Virginia	x	x	
Wisconsin		x	x
Wyoming	x		not available

health education at the elementary level, only 18 states require teacher preservice courses in health education. In approximately 16 states, elementary teachers are mandated to teach health education--even though preservice health education courses are not required. In those same states there are no written state curriculum guides in health education. Additionally, some of the 26 curricular guides that do exist are not current. Several are ten or more years old and many are merely guides for how to develop curricula. That is, they provide objectives and frameworks but no specific guides for how to implement health education. The literature suggests that practical information may be of more assistance to poorly prepared teachers than philosophical statements.

This analysis of how elementary school teachers are prepared for teaching health education in grades K-8 raises some interesting issues. It appears that states have been far more intent on mandating curricular content (most specify drug and alcohol abuse prevention instruction) than they have been in requiring teachers to acquire the knowledge, skills, and tools needed for implementing these mandates. How can elementary classroom teachers provide mandatory health education without the necessary skills and information to do so? Under these circumstances, is it even reasonable to assume that quality health information or instruction can be provided in the nation's elementary schools? It appears that states are placing unrealistic expectations concerning comprehensive school health education upon elementary classroom teachers.

Health instructors are those individuals who have not been certified in health education, but who provide instruction related to health in middle schools, junior high schools, and high schools. They may have one of a variety of roles--social science teacher, school nurse, physical educator, science educator, or home economist. Health instructors are sometimes referred to as health teachers. The majority of health teachers have had preservice courses in some specialized content area related to comprehensive school health (e.g., consumer protection, vision and hearing, physical fitness, causes of disease, nutrition).

Since health instructors have such a wide variety of preservice backgrounds, it is impossible to assess the extent of their academic training. It is apparent, however, that many may lack a broad background in comprehensive school health education, skill in specific health education teaching methodology, and experience in specific health education field practica. The fact that they lack certification in health education is evidence that they are not prepared to teach it. (It is important to note that some states do require subject matter certification for those individuals who teach health in departmentalized middle and junior high schools. In such cases, these individuals should be classified as health educators, not health instructors. In this monograph, health instructors are defined here as individuals who are not certified in health education.)

Although health instructors are not certified in health education, they can still make a valuable contribution toward school health education. Their contributions, however, may be of lesser quality than those provided by certified health educators.

Since health instructors and health teachers are required to provide mandatory health education in the public schools, there is reason for concern about their level of expertise. How effective these individuals really are in the overall picture of comprehensive school health education is a matter of conjecture. In order to answer this question, research is needed that addresses the academic preparation of health instructors and their role in school health education.

Health Educators

As we have pointed out, many educators contribute to school health education. The certified health educator, however, is the primary specialist in the field. Health education specialists are expected to use their behavior-change skills along with their knowledge of health content and methodology to develop a comprehensive school health education program. According to the Role Delineation Project, certified health educators are theoretically "prepared to assist individuals acting

separately or collectively, to make informed decisions regarding matters affecting their personal health and that of others." (U.S. Department of Health and Human Services, National Center for Health Education 1980-81).

Statistics from "Health Education Manpower (U.S. Department of Health and Human Services, Health Resources Administration, 1982) show that there are approximately 25,000 health educators in the nation. Statistics indicate that school health educators constitute the largest subgroup (20,000) within this category. This estimate is substantiated by figures from the National Center for Education Statistics, which reported a total of 15,958 baccalaureate graduates from 156 degree programs between 1970-71 and 1978-79 (U.S. Department of Education, National Center for Education Statistics 1982, p. 258). These statistics do not provide answers to two very important questions, however: (1) How many of these approximately 20,000 school health educators are currently employed in the school workforce? and (2) Of those individuals who are currently in the school workforce acting as school health educators, how many are not graduates of professional preparation institutions? Persons who are not graduates of such institutions are considered to be health instructors, not health educators.

Several attempts have been made by professional health organizations to establish a profile of the comprehensive health educator. These attempts have not produced a composite profile. Health educators are a homogeneous group but possess diverse characteristics.

Yet, by compiling information from a variety of sources, it is possible to make some assumptions about health educators. First, one can assume that most certified health educators are younger than the average public school teacher, since specialized certification in school health education is a fairly recent development.

Second, one can assume that the majority of health educators are Caucasian. In the health professions, which includes health education, minorities are traditionally few. (U.S. Department of Health and Human Services, Human Resources Administration 1980).

Third, it can be assumed--based on the estimate of 20,000 school health educators--that a large number of

school health educators do not belong to any national professional organization. As of 1982, the two largest national professional organizations--the American Alliance for Health, Physical Education, Recreation and Dance and the American School Health Association--reported a collective health (teacher) membership of only 4,110.

Fourth, one can assume that school health educators--like all educators--perform a variety of tasks in schools. No doubt, health educators are also counselors, lunchroom supervisors, athletic coaches, school activity coordinators and club advisors.

Fifth, one can assume that health educators graduated from a host of colleges and universities that are diverse in faculty size, organizational makeup, and in program quality and quantity (Koski n.d.). As of 1982, more than 261 institutions offered baccalaureate degrees in school health education (Moore 1982). These teacher preparation institutions cooperate with their respective state agencies in the health education certification process.

Sixth, we can assume that an analysis of certification requirements will yield some insight into the profile of the school health educator. Such an analysis must be thorough, particularly in view of the lack of uniformity in state certification policies. As Marian Hamburg so clearly pointed out at the 1981 National Conference for Institutions Preparing Health Educators:

> There is lack of uniformity in the way school health educators are prepared across the country . . . . In fact, the wide variations of State requirements for professional programs have resulted in differences in range and depth of subjects studied, duration of the curriculum, nature and amount of field work, minimum competency expectations, and the qualifications of faculty leadership. Not only do the standards vary, but so does the monitoring process. Standards on paper are not necessarily those in practice. Professional preparation of school health educators in the United States is not one, but many things. (1981)

With this warning in mind, this author suggests that, although certification requirements do vary, such an analysis is not entirely meaningless. Certification status, however, does not provide a complete picture. That is because school health education certification varies by state. So also does the practice of dual certification (i.e., combined certification or endorsements offered in more than one teaching specialty; total number of hours required for a combined certification is frequently less than the hours required for each specialty when attained separately. However, many states are finally discounting the practice of dual certification. (See Appendix C for a position statement regarding school health education certification.)

Available data suggest that proponents of a comprehensive school health education program--who equate certification with qualification--should exercise caution in linking certification with high calibre instruction. Numbers of teachers certified may in fact only represent the growth of the profession, not the quality of those certified. On one issue, professional health educators resoundingly agree--that full implementation of comprehensive school health education will be enhanced significantly by increased employment of qualified school health educators.

Data synthesized from the School Health in America survey point out some interesting disparities between what is mandated and what actually exists state by state in secondary health education. Analysis of the data indicates that (1) a considerable number of states are committed to the concept of comprehensive school health education, mandate specific content, and require health education for graduation; (2) states hold different expectations for health education in their public schools; (3) different types of certification exist for those who teach health at the secondary level; (4) some states are consistent in making available curricular tools, policy, and special funding for health education while others expect health education to take place in their public schools but do not provide adequate means for meeting this expectation; (5) all states that report a comprehensive school health education program (K-12) do not require health education in order to graduate from high school.

For several reasons caution must be exercised in drawing conclusions or making generalizations from these data about the quality of health education. First, policy is constantly in flux. Numerous states may have developed educational policies since these data were collected. Second, curricular guides or tools for implementing health education may also have been issued since these data were published. Third, some states that provide for separate health certification also make provisions for dual health and physical education certification, This would tend to cause discrepancies in some of the data generated in the School Health in America survey. For instance, when states reported to the survey on health education certification, they may have reported only on separate health education certification. Additionally, a significant difference may exist between requiring and making available a separate health education certificate. Finally, in different states "separate health education certification" and "health endorsement" may have similar or very different meanings.

Taking into account possible discrepancies in reports of certification requirements, two other significant considerations at both the state and local levels demonstrate the complexity of the certification issue. These are the practice of misassigning teachers and the ramifications of "grandfathering."

In rural public schools and in schools where scheduling arrangements create isolated or extra sections of health education classes, noncertified staff are often assigned to teach health. Since these people are not certified health educators, one cannot assume that, in states where health education exists, all secondary health classrooms are directed by certified health educators.

Similarly, many states provide for the certification of unqualified health educators through "grandfather" clauses which allow those who were once certified in dual areas to continue teaching, despite the fact that separate health education certification has been enacted.

People certified under grandfather clauses may not be up to date in health education teacher preparation. As a result, it cannot be presumed that in those states where health education is required and where separate health education certification exists, that all secondary health

classrooms are directed by teachers who are qualified and separately certified in health education. In these instances, if health education inservice is not required, then professional growth often becomes a matter of personal choice and can be limited by the availability of opportunities to pursue further education.

Certification, lacking both uniformity and compliance in actual practice, is thus a complex issue. The issue becomes particularly complex when related to the mandate of comprehensive school health education. Acknowledging these caveats, let us now examine who should teach health.

The Ideal State of Health Education

It is evident from a review of the literature that methods of putting health education into practice in schools are lacking in terms of both curricula and personnel. If we as a nation accept the premise that instruction in health is essential or basic, it is imperative that both past and present weaknesses in curricula and personnel be eliminated.

School Health Education

In a step to eliminate these weaknesses, numerous professional organizations have drafted resolutions and position statements concerning health and health education. Although these resolutions and documents serve primarily as guidelines for those who design, implement, and ultimately evaluate school health programs, they also are important reflections of the state of the art and the direction of the profession. The statements come from a variety of sources--educational organizations, medical academies, and health professional groups. Samples of resolutions and position statements appear in Appendix A.

An analysis of these statements indicates clearly that (1) school health education is considered an educational basic; (2) school health education should be implemented in a comprehensive rather than a fragmented manner and (3) school health education should be an ongoing, dynamic process. These statements are compatible

with the Comprehensive School Health Education Operational Definition laid out in Appendix B. Appendices A and B specifically identify school health education content and curriculum. In light of curriculum recommendations, we come up against the knotty question of just what are the qualifications needed by teachers of health?

School Health Education Personnel

Concern about adequate academic preparation for teachers of health is not new. According to Bruess and Gray, John Locke in the 1700s and Horace Mann in the 1800s addressed the need for this preparation (Bruess and Gray 1978). Within the last twenty years, the professional literature on health education has been replete with suggestions on how to improve preparation. Those particularly interested in a brief chronological overview of professional preparation of health educators are referred to the work of William Creswell (1981).

Suggestions have ranged from requiring teacher physical examinations to mandating nationwide continuing education credits. From the vast body of literature focusing on professional preparation, two current sources offer significant guidelines. Both offer direction to teacher preparation institutions and provide a framework that is independent of the certification process as it currently functions.

The first, Professional Preparation in Safety Education and School Health Education, represents the collective work of 60 health educators who participated in the working sessions of the School Health Division at the American Alliance for Health, Physical Education, and Recreation's (AAHPER) National Conference on Undergraduate Professional Preparation in 1973 (AAHPER 1974). This document--commonly referred to as the "New Orleans Document"--consists of two sections pertinent to school health education: (1) the NCATE Standards, which apply specifically to teacher preparation in health education at the undergraduate level, and (2) an interpretation of the NCATE Standards that deals with recommendations on teacher competencies and suggestions for behavioral objectives in health education. This document--particularly Part II--is

significant because it designates teacher competencies or skills as the basis for professional preparation. These 95 recommended health educator competencies or skills address each area of preparation: content for teaching specialty, contributions to subject matter of health education from allied fields, teaching and learning theory, laboratory and clinical experience, practicum, organization and administration, and public relations and personal qualifications of the health educator.

The second, a series of documents which focus on the Role Delineation Project. Although all five phases of the project have not yet been finished, Phase II is complete. Its purpose was to verify the roles, responsibilities, and skills that pertain to entry-level health educators. Data so far indicate that all health educators in entry-level positions in all settings use the same basal skills and knowledges (Henderson 1982). These skills and knowledges have been broken down into seven areas of responsibility, each with specified functions and each with specified skills or activities. Although other factors vary, these basal skills and knowledges are of special importance because they provide a basal description of the "generic health educator." This description not only sets up a means for quality control for the profession in the future but also gives direction to institutions currently training teachers. Other phases planned for the Role Delineation Project are developing curricular guides for use in professional preparation programs, assessing institutions, and, ultimately, establishing a credentialing process that will ensure quality health education practitioners.

Future Application, Educational Training, and Requirements

Let us now look toward future directions, keeping in mind that these two sources (Professional Preparation in Safety Education and School Health Education and the Role Delineation Project papers--"The Refined and Verified Role for Entry-Level Health Educators," Role Refinement for Health Education, and Initial Role Delineation for Health Education) have both addressed competencies and skills of health educators. Potential solutions to the barriers

previously identified in this document may be best addressed by looking at competencies and skills as these two sources have.

A review of the literature has revealed four barriers to attaining competent health education. These barriers are: (1) lack of emphasis on modeling and showing the relevance of healthy lifestyles by all school personnel; (2) lack of uniformity in requirements for elementary teacher health education preservice courses; (3) lack of compliance with existing certification requirements at both the state and local levels; and (4) lack of uniformity in certification across the nation. Since we know that full implementation of comprehensive school health education depends on the quality and professional preparation of all school personnel, certain recommendations for the educational training and requirements of school health personnel emerge. The recommendations are consistent with and supported by major documents that have been cited.

Recommendation 1: All school personnel should have at least a basic health education course. If such a course was not a part of preservice training for those now working in schools (as may be the case with administrators, custodians, or secretaries), inservice should be provided.

Such a course should focus on promoting health and preventing disease. The course should include individualized health assessment and an analysis of health behaviors. Additionally, it should teach skills that are useful in making lifestyle changes and should stress the significant influence adults have on youths who model their behavior.

Recommendation 2: All persons seeking elementary education certification should have at least the basic health education course.

If such coursework was not a part of preservice, inservice should be made available. An additional course should also be requisite. The additional course should focus on components of comprehensive school health as well as methods and materials specific to health education.

Recommendation 3: All persons seeking health education certification should have completed a series of preservice courses in a major area of academic concentration in health education. These courses must have met criteria established by a recognized national health education body. If preservice coursework of certified individuals currently employed in the field did not meet these standards, five years should be allowed to complete appropriate inservice and postgraduate work.

A course in health promotion and disease prevention should be the focal point of the major area of academic concentration in health education. This "basic" course should allow for individualized health assessment, analysis of lifestyle health behaviors and acquisition of skills useful in making lifestyle changes. This course should stress the significant modeling influence that adults who work in schools have on youth.

Academic concentration in health education should also include content courses that deal with comprehensive school health education, methods and materials targeted to health education, and the dynamic nature of health education which changes as society and the educational system change.

In addition to the study of sciences such as biology, health educators should take courses in educational theory, communication skills, political science, and social science.

Persons concentrating in health education should also take part in practical field experiences and internships in a wide variety of health education settings.

Recommendation 4: All persons seeking recertification should (a) be able to demonstrate their retention of basic health education knowledge and skills by passing a credentialing examination and (b) be able to document their professional updating by completing approved educational coursework or experiences within a five-year period.

A proficiency examination for recertification should be nationally approved or should follow national guidelines. The exam should be compiled from the health education domains included at the preservice level.

That part of the updating process that involves courses and/or experiences should be approved by state, local, or regional professional organizations.

Suggestions for putting these recommendations into practice are discussed in the following section. The reader is reminded that in order for these recommendations to be implemented, cooperation at the national, state, and local levels is vital.

Strategies for Enhancing Teacher Preparation

Since a symbiotic relationship exists between comprehensive school health education and those who teach health, it is important that both be improved. A number of strategies for improvement, aimed at the national, state, and local levels, have been advanced by various education professionals.

National Strategies. Continued efforts need to be directed toward opening lines of communication between different national health education organizations. The Coalition of National Health Education Organizations, whose task it is to promote and enable coordination, collaboration, and communication among member organizations, is an excellent vehicle for sponsoring discussion of health education issues. Collective actions taken by this umbrella group have provided the impetus for health agencies, professional organizations, and educators to work in unison.

The goal of the Role Delineation Project--to identify and measure the knowledge and skills needed by health educators--points to the future direction of health education on a national level. When completed, this project will establish a mechanism for credentialing entry-level health educators, resulting in a major step toward assuring uniformity of requirements among future secondary health educators. However, strong professional leadership will be needed to complete this project. What is evident is that such a process would reduce the disparity in certification requirements and practices that currently exists among states. An obvious by-product of

credentialing would be the upgrading of standards and programs for teacher preparation at many institutions of higher education.

Until the Role Delineation Project is finalized, states should encourage separate health education certification as recommended by the Association for the Advancement of Health Education (AAHE) (See Appendix B). Separate certification in health more thoroughly guarantees the acquisition of specific professional development skills, and schools throughout the nation should insist upon some type of certification for every teacher involved in health instruction.

Teacher preparation programs for the elementary school level should include health education requirements. Joint efforts between professional health education organizations and education organizations such as NCATE and American Association of Colleges for Teacher Education could result in health education standards for elementary teachers (Baer 1982). Adding a substandard in health education as a condition for certification would prompt teacher preparation institutions to include a health requirement.

State Strategies. Membership and active involvement in health-related organizations is a key to continued professional growth. Since national organizations do not fully represent the total range of individuals involved in teaching health, educators must seek new avenues to promote professional involvement. Participation in state and regional organizations can ease the budgetary constraints on professional travel to distant meetings (as well as the lack of opportunities for quality continuing education). Involvement in health coalitions at the state and regional levels can help meet the need for professional involvement.

The Education Commission of the States (ECS) believes that state education policymakers can play an important role in promoting health education as part of the total school curriculum. State policymakers, ECS contends, can improve the delivery of health education programs and provide state-level assistance. ECS has focused on five promising strategies currently being used by states to promote and enhance the implementation of health education

programs in local school systems.

Each of these strategies directly or indirectly holds potential for affecting the quality of school health education and thus the potential for influencing professional preparation. These strategies are: (1) weave health into basic education (that is, stipulate knowledge of health as an "essential" skill, competency, or learner outcome); (2) develop cooperation and coordination between agencies that have overlapping responsibilities in health; (3) devise techniques to improve the efficiency and effectiveness of state technical assistance devices--such as curriculum guides, assessment tools, or checklists--so that personnel can function with minimal assistance from specialists; (4) educate and train teachers, administrators, and other support personnel to be effective health educators (inclusion of "nonteaching" personnel is based on the premise that all school personnel have the potential for being informed "health educators" since health education takes place in a variety of settings outside the classroom); and (5) develop a broad-based coalition in support of school health education (coalitions should include representatives from both the public and private sector who back school health education). All five strategies have potential for creating a coalition of advocates for health education.

Local Strategies. Local approaches to gaining support for quality health education depend largely on making parents and community educators aware of the goals of comprehensive school health education. An excellent prototype for accomplishing this in the local community comes from the National Congress of Parents and Teachers (the "PTA") (National Congress of Parents and Teachers, 1981). State and local educators who have used this approach say the action plan affected positively the scope and quality of local school health programs.

What this plan points to--to achieve comprehensive school health education--is good teaching. Local school districts must employ qualified school health educators. Without their expertise, comprehensive health programs cannot be built. As Willgoose points out:

> Teaching is an art as well as a science and, as such, requires the very best creative effort the health educator has to offer...In short, there must be life in the teaching and in the program--the kind of life and commitment that is required by the "here-now" adolescent generation, and the kind of life and commitment that is required in order to know and understand students as people. This is no small side-line task. Creating opportunities for students to think, explore and feel the forces that influence well-being is a major vocation...These experiences can be provided through the time-consuming and joyful art of teaching, if a total commitment to comprehensive health education is embraced by the school health educator. Anything short of this will be inadequate and misleading, for we will have professed to have an aim and then neglected the means of execution. (1981, p. 439)

Summary

Improving the quality of individuals involved in the process of health education, be they classroom teachers, librarians, or specialists, involves educating all to become effective health educators. Despite the specialization that the educational system requires, each of these individuals holds a primary responsibility to model healthy lifestyles and to teach for relevance. In order to achieve the real, comprehensive school health education, local, state, and national coalitions need to work for more effective health education credentialing that is directed toward competencies and skills.

The task is not an insignificant one. Our future as a nation of healthy individuals rests on the success of this venture.

REFERENCES

Allanson, John F. "Comprehensive School Health Education: Maltese Chicken or Phoenix?" The Journal of School Health 51, 8 (October 1981): 556-9. (ERIC No. EJ 252 939.)

Alles, Wesley F., and Eddy, James M. "Ten-Year Survey of Public Attitudes Toward Education: Implications for Health Education." Journal of School Health 50, 2 (February 1980):62-5. (ERIC No. EJ 233 208.)

American Association for Health, Physical Education, and Recreation. Professional Preparation in Safety Education and School Health Education. Report of a National Conference on Undergraduate Professional Preparation, Washington, D.C., 1974. (ERIC Document Reproduction Service No. ED 092 499.)

_____. "Standards and Guidelines for Teacher Preparation in Health Education." Journal of Health, Physical Education and Recreation 40, 2 (February 1969):31-8. (ERIC No. EJ 001 726.)

American Association of Colleges for Teacher Education. "Paths to Accreditation." (Special Issue) Journal of Teacher Education 29, 1 (January/February 1978).

American Public Health Association. "Accredited U.S. Schools of Public Health and Graduate Public Health Programs 1979-80." American Journal of Public Health 70 (March 1980):329.

Arnstein, George. "Two Cheers for Accreditation." Phi Delta Kappan, 60, 5 (January 1979):357-61. (ERIC No. EJ 193 980.)

Association for the Advancement of Health Education. "Comprehensive School Health Education: An Operational Definition." HE-EXTRA 5, 1 (Summer 1980):3.

_____. "Education Commission of the States: State Strategies for Implementation of School Health Education." HE-EXTRA 8 (Fall 1982):1, 4.

Association of Teacher Educators. "Certification and Accreditation in Teacher Education." Action in Teacher Education 1, 3-4 (Spring/Summer 1979).

Astin, Alexander et al. Evaluating Educational Quality: A Conference Summary. Washington, D.C.: Council on Postsecondary Education, 1979.

Baer, Roberta. Interview with the National Center for Health Education, San Francisco, California, 20 October 1982.

Bedworth, David A. "A State Health Education Program Revisited." Health Education 8, 1 (January/February 1977):29-30. (ERIC No. EJ 161 299.)

Bennett, Bernice E. "A Model for Teaching Health Education Skills." Health Education 8, 5 (Sept./Oct. 1977):15-18. (ERIC No. EJ 172 722.)

Bowman, Robert A. "Changes in Activities, Functions and Roles of Public Health Educators." Health Education Monographs 4 (Fall 1976):226-46.

Brodinsky, Ben. Defining the Basics of American Education. Phi Delta Kappa Educational Foundation, 1977.

Bruess, Clint E., ed. "Professional Preparation of the Health Educator." Journal of School Health 46 (September 1976):418-21.

Bruess, Clint E., and Gray, John E. Implementing Comprehensive School Health. New York: Macmillan, 1978.

Carson, Sue, as told to Jim Schoit. "Blueprint for Health: Build It!" The Journal of School Health 51, 8 (October 1981):573-74.

Chronicle of Higher Education. "Debate Intensifies Over Federal Role in Accreditation." 21 May 1979.

Cohen, Harris S. "On Professional Power and Conflict of Interest: State Licensing Boards on Trial." Journal of Health Politics, Policy and Law 5 (Summer 1980):291-308.

_____. "Public Versus Private Interest in Assuring Professional Competence." Family and Community Health 2 (November 1979):79-85.

Council on Postsecondary Accreditation. Abridged Summary of the Project to Develop Evaluative Criteria and Procedures for the Accreditation of Nontraditional Education. Assessing Nontraditional Education. Vol. 1. Washington, D.C., September 1978.

_____. A Joint Policy Statement by the Council on Postsecondary Accreditation and the Council of Graduate Schools in the United States. Accreditation of Graduate Education. Washington, D.C., May 1978.

_____. The Balance Wheel for Accreditation. Washington, D.C., published annually.

Cousins, Norman. "The Anatomy of an Illness (As Perceived by the Patient)." Health Education 9, 1 (January-February 1978):8-13. (ERIC No. EJ 182 353.)

Crase, Darrell. "Needed Comprehensive Profiles of Health Educators." The Journal of School Health 51, 6 (August 1981):391-93. (ERIC No. EJ 249 382.)

_____. "Ten Years in Health Education." Health Education 12, 6 (November/December 1981):11-12. (ERIC No. EJ 255 716.)

Creswell, William H., Jr. "Preparation for Health Teaching." Journal of Health, Physical Education and Recreation (May 1964):33-34.

_____. "Professional Preparation: An Historic Perspective." Paper presented at the National Conference for Institutions Preparing Health Educators, Birmingham, Alabama, 1981. Reprinted in Conference Proceedings, pp. 46-60. Washington, D.C.: U.S. Department of Health and Human Services.

Dosch, Peg, and Paxton, Cindy. "Recharging Professionally: The Oregon Seaside Conferences." Health Education 12, 6 (November/December 1981):34-35. (ERIC No. EJ 255 724.)

Education Commission of the States. Recommendations for School Health Education: A Handbook for State Policy Makers. Report No. 130. Denver, Colo.: Education Improvement Center, March 1981. (ERIC Document Reproduction Service No. ED 206 103.)

_____. State Policy Support for School Health Education: A Review and Analysis, Report No. 18201, Denver, Colo.: Education Improvement Center, June 1982.

Finkin, Matthew W. Federal Reliance on Educational Accreditation: The Scope of Administrative Discretion. Washington, D.C.: Council on Postsecondary Accreditation, 1978.

Fitsch, James A. "Summary and Highlights Conference for Institutions Preparing Health Educators. Birmingham, Alabama, 1981." Health Education 12, 4 (July/August 1981):40-42.

Green, Lawrence W. "Suggested Procedures for Moving from Programmatic Accreditation to Peer Review Under Broader Institutional Accreditation." In "Health Education Manpower," Health Education Monographs 4 (Fall 1976):278-84.

Green, Lawrence W. et al. Health Education Planning: A Diagnostic Approach. Palo Alto, Calif.: Mayfield Publishing Company, 1980.

Grosshans, Onie R. "Traditional Outlooks for a New Century." Health Education 11, 2 (March/April 1980):18-19. (ERIC No. EJ 226 554.)

Hamburg, Marian V. "Credentialing: Implications for (School) Health Education." Paper presented at the National Conference for Institutions Preparing Health Educators, Birmingham, Alabama, February 6, 1981. Reprinted in Conference Proceedings, pp. 114-18. Washington, D.C.: U.S. Department of Health and Human Services, 1981.

Haralson, Mabel. "The Teacher In-Service Workshop Delivered the Goods." Journal of School Health 50, 2 (February 1980):69-73. (ERIC No. EJ 233 210.)

Harcleroad, Fred. Voluntary Organizations in America and the Development of Educational Accreditation. COPA Occasional Paper. Washington, D.C.: Council on Postsecondary Accreditation, 1980.

Harris, John, and Casey, Robert. Accreditation and Accountability. Occasional Paper. Washington, D.C.: Council on Postsecondary Accreditation, 1979.

Henderson, Alan C. "The Refined and Verified Role for Entry-Level Health Educators." The Eta Sigma Gamma Monograph Series 1 (September 1982).

Henderson, Alan C., and Cortese, Peter A. "Legislative Advocacy in Health Education: A Case Study." Health Education 12, 2 (March/April 1981):25-27.

Houchbaum, Godfrey M. "Health Education as a Profession: Reality or Illusion?" Health Education 13 (November-December 1982):4-7.

Houle, Cyril O. "Continuing Professional Education." Paper presented to the New York State Board of Regents Conference on the Professions, November 1977, New York, N.Y.. Photocopied.

Howell, Keith A. "Visions on the Future of Health Education." Health Education 11, 2 (March/April 1980):24-25.

Ilich, Ivan. Deschooling Society. New York: Harper and Row, 1968. (ERIC Document Reproduction Service No. ED 070 247.)

Jean, Sally Lucas. "Stars to Steer By." American Journal of Public Health. (August 1951):963-70.

Kilander, H.F., ed. Preparing the Health Teacher. Washington, D.C.: American Alliance for Health, Physical Education and Recreation, 1961.

Kolacki, Eugene C. "How to Plan Inservice Health Education for Elementary Classroom Teachers." Health Education 12, 2 (March/April 1981):32-34.

Kolbe, Lloyd J. "What Can We Expect from School Health Education?" The Journal of School Health 52, 3 (March 1982):145-50.

Koski, Arthur. "A National Study of Administrative and Curricular Practices of Departments of Health, Health Education, and Health Science, 1978." Corvallis: Oregon State University Department of Health. Photocopied. n.d.

Kreuter, Marshall W., and Dwore, Richard B. "A Case for Health Promotion." Paper presented at the First Annual Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Conference on Prevention, 12 September 1979, Silver Spring, Md. Photocopied.

Landwer, Gerald E. "Where Do You Want to Go?" The Journal of School Health 51, 8 (October 1981):529-31.

Lasch, Henry A. "Organizational Patterns of College Health Education Programs." Health Education 8 (September/October 1977):19-21.

McDermott, Robert J. "Open Up the Lines of Communication." The Journal of School Health 52 (November 1982):518-19.

McKeever, Robin. Interview with American School Health Association, Kent, Ohio, 15 October 1982.

Means, Richard K. Historical Perspectives on School Health. Thorofare, N.J.: C.B. Stack, 1975.

Meyer, Virginia Young. "Health Education for Prospective Teachers: Is It Effective?" The Journal of School Health 52, 8 (October 1982):491-94.

Moore, Linda M. "AAHE Directory of Institutions Offering Specialization in Undergraduate and Graduate Professional Preparation Programs in Health Education: 1983 Edition." In Health Education 13, 5 (September/October 1982):31-39.

_____.Interview with Association for the Advancement of Health Education, Reston, Virginia, 5 November 1982.

National Commission for Health Certifying Agencies. Perspectives of Health Occupational Credentialing. DHHS Publication No. (HRA) 80-39. Washington, D.C., April 1980.

_____. Reports 2 (September 1980).

National Congress of Parents and Teachers. Health Education Matters: Comprehensive School/Community Health Education Project. Chicago: 1981.

National Council for Accreditation of Teacher Education. NCATE Twenty-sixth Annual List 1979-1980. Washington, D.C.: 1980.

National Council on Measurement in Education. Journal of Educational Measurement. Special Issue on Standard Settings. 4 (Winter 1978).

Newman, Ian M. "JOSH a Good Forum for Expression of Differing Opinions." The Journal of School Health 52 (November 1982):519.

Nolte, Ann E. "Significance of Historical Research in Health Education." Health Education 11, 6 (November-December 1980):40-41.

Peterson, Dorothy G. Accrediting Standards and Guidelines: A Current Profile. Washington, D.C.: Council on Postsecondary Accreditation, 1979.

Peterson, Dorothy G., ed. A Guide to Recognized Accrediting Agencies. Washington, D.C.: Council on Postsecondary Accreditation, 1980.

Pigge, Fred L. Opinions About Accreditation and Interagency Cooperation: A Nationwide Survey. Washington, D.C.: Council on Postsecondary Accreditation, 1979.

Popham, W.J. Criterion-Referenced Measurement. Englewood Cliffs, N.J.: Prentice-Hall, 1978.

Pottinger, Paul. "Taking License: An Issue Has Come of Age." Pro Forum 1, 10 (March 1979).

Price, James H. "An Alternative Theory for Implementing Quality School Health Education." The Journal of School Health 52, (April 1982):264.

Rapoport, Anatol. Operational Philosophy. New York: Harper and Row, 1953.

Salman, Raymond D. "Continuing Competence and the Credentialing of Professionals." Keynote address to the Third Annual Education Conference of the National Commission for Health Certifying Agencies, December 1979, New Orleans, Louisiana. Photocopied.

_____. "National Examinations for Professional Licensing: Concepts and Issues." Address to the American Association of State Social Work Boards, New Rochelle, New York, November 1980.

Schaller, Warren E. "Professional Preparation in Health Education." School Health Problems. Springfield, Ohio: Charles C. Thomas Co., 1981.

School Health Education Study. Health Education: A Conceptual Approach to Curriculum Design. St. Paul, Minn.: Education Press, 1967.

Sechrist, William. "Writer's View Is Soley His." Journal of School Health 52 (August 1982):329.

Selden, William K., and Porter, Harry V. Accreditation: Its Purposes and Uses. COPA Occasional Paper. Washington, D.C.: Council on Postsecondary Accreditation, 1977.

Shimberg, Benjamin. "National Developments in Health Occupations Credentialing." Photocopied. 1980.

_____. "Testing for Continued Competence: No Longer the Impossible Dream." Paper presented to the New York State Board of Regents Conference on the Professions, November 1977, New York City. Photocopied.

Shirreffs, Janet H. "Health Education: An Emerging Profession." Health Education 11, 4 (July/August 1980):7-10. (ERIC No. EJ 235 406.)

Sims, Joseph. "The Professions at a Crossroads: More Regulation or Less?" Paper presented to the New York State Regents Conference on the Professions, 1979, New York. Photocopied.

Society of Public Health Education. "Report of the 1972-73 Joint Committee on Health Education Terminology: New Definitions." Health Education Monographs 33 (1973).

Taub, Alyson. "Health Education: A Profession?" Health Education 11, 2 (March/April 1980):26-27.

Thrash, Patricia A. "Accreditation." The Journal of Higher Education 50, 2 (March/April 1979).

Toffler, Alvin. Future Shock. New York: Random House, 1970.

Toohey, Jack V., and Shirreffs, Janet H. "Future Trends in Health Education." Health Education 11, 2 (March/April 1980):15-17.

Torney, John A. "Legislative Action for Health Education: California Update." Health Education 12, 6 (November/December 1981):28-30.

Tritsch, Len. "School Health Education Today, As I See It." Health Education 6, 1 (January/February 1975):5-6.

U.S. Department of Education. Guide to Undergraduate Degree Programs in the United States. Prepared for the National Institute of Education by Carol P. Sosdian and Laure M. Sharp. Washington, D.C.

U.S. Department of Education, National Center for Education Statistics. Reported in Public Health Personnel in the United States, 1980. Washington, D.C.: U.S. Department of Health and Human Services, January 8, 1982, p. 258.

_____. National Center for Health Education. Role Refinement for Health Education. Washington, D.C., 1981.

U.S. Department of Health and Human Services, Bureau of Health Education. Focal Points. Washington, D.C., July 1980.

U.S. Department of Health and Human Services, Division of Associated Health Professions, Bureau of Health Professions. "Background Statement for Credentialing Program Sponsored by Bureau of Health Professions." Hyattsville, Md., April 1980.

U.S. Department of Health and Human Services, Health Resources Administration. Public Health Personnel in the United States, 1980. DHHS Publication No. (HRA) 82-86. Washington, D.C., 1982.

U.S. Department of Health and Human Services, National Center for Health Education. Initial Role Delineation for Health Education. Washington, D.C., 1980.

U.S. Department of Health and Human Services. Proceedings of the National Conference for Institutions Preparing Health Educators. Washington, D.C., 1981.

U.S. Department of Health and Human Services, Public Health Service. Promoting Health--Preventing Disease: Objectives of the Nation. Washington, D.C., 1980.

U.S. Department of Health and Human Services, Public Health Service. School Health in America: A Survey of State Health Programs. Prepared for the Center for Health Promotion and Education by Diane DeMuth Allensworth, Ann Sales Castile, and Mary Noak; 3rd ed. Kent, Ohio: American School Health Association, 1981.

U.S. Department of Health, Education and Welfare, Health Resources Administration. Developments in Health Manpower Licensure: A Follow-up to the 1971 Report on Licensure and Related Health Personnel Credentialing. DHEW Publication No. (HRA) 74-2101. Washington, D.C., 1973.

U.S. Department of Health, Education, and Welfare, Office of Education. "Nationally Recognized Accrediting Agencies and Associations." Reprinted in Federal Register, 19 January 1979, pp. 4017-4020.

U.S. Department of Health, Education and Welfare, Public Health Service. Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention. DHEW (PHS) Publication No. 79-55071. Washington, D.C., 1979.

Vincent, Murray L., and Gallagher, Neil E. "Health Educator Preparation Via Other Disciplines?" The Journal of School Health 50, 10 (December 1980):593-94.

Weinberg, Armin D.; Baldi, Susan; and O'Rourke, Thomas. "Profile Report: ASHA Member Survey." The Journal of School Health 51, 8 (October 1981):552-55.

White House Conference on Regulatory Reform. Proceedings, 1980 White House Conference on Regulatory Reform. Washington, D.C., 1980.

Wilks, Barbara. "A Survey of Health Educators Regarding a Health Education Area Test in the National Teacher Examinations." Health Education 12, 4 (July/August 1981):31-33.

Willgoose, Carl E. "School Health Educators As School Health Educators." The Journal of School Health 51, 6 (August 1981):439.

Woellner, Elizabeth H. Requirements for Certification: Teachers, Counselors, Librarians, Administrators. Chicago: University of Chicago Press, 1981.

World Health Organization. "Constitution of the World Health Organization." Chronicle of the World Health Organization 1, 3 (1947):3.

Young, Kenneth, ed. Understanding Accreditation. San Francisco: Jossey-Bass, in press.

APPENDIX A

SUPPORT FOR COMPREHENSIVE SCHOOL HEALTH EDUCATION
American Academy of Pediatrics (1963)

The American Academy of Pediatrics believes that it is necessary to reaffirm its support for the concept of school health education from kindergarten through grade 12 for all school children in the United States:

1. Health education is a basic education subject and should be taught as such.--1978.
2. A comprehensive health education program should include the following subjects: courses that yield an understanding of basic biology, physiology, and genetics; accident prevention; venereal disease; alcoholism; mental health; parenting; sex education; drug abuse; environmental and consumer health; and preventive medicine.--1978.

Fragmentation in Health Education

While reaffirming the need for health education to combat venereal disease and other serious individual health problems, the American School Health Association deplores the tendency evidenced lately of fragmentation in the field of health education. Health instruction should be a well-delineated and carefully organized program, with proper attention to sequence and scope throughout the school and college years. Under no circumstances should health instruction be fragmented into separate courses or compartmentalized into segments covering venereal disease, sex education, nutrition, or other special topics. The

importance of these areas is unquestioned and each should be given an appropriate and significant place in the overall health education curriculum. Health education for optimum value to students, however, must be a unified, integrated, cohesive program with proper concern for all aspects of personal, family, and community health.--1966 Resolution.

Health Education--An Academic Subject

In some states legislative specification of areas of the educational curriculum as "academic" or "non-academic" is taking place. The American School Health Association affirms that health education, drawing from and interpreting objective findings from the natural and social sciences for the purpose of assisting man's functioning at optimal level, should be designated as an academic subject.--1963 Resolution

Health Instruction Required in Schools

In some communities public pressure concentrated on the so-called "solid subjects" had led to the hasty and unwise elimination of the health education requirement in the school curriculum. The American School Health Association, recognizing that good health is basic to all other forms of excellence, urges that the health education requirement be restored where this provision has been eliminated and that where no requirement presently exists such a provision be instituted with all deliberate speed.--1963 Resolution.

COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM RESOLUTION
The National Parent-Teacher Association
Board of Managers (1970)

The National PTA is vitally interested in the teaching of health in the public schools. The school health curriculum has been fragmented into separate programs in such areas as drug abuse, venereal disease, environmental health, and family life education. Many local school districts have combined health education and physical education programs. There is a need for a comprehensive program of health instruction in our schools which will meet the total needs of all children and youth, therefore be it RESOLVED:

That the National PTA lend its full and active support to the development of an identifiable comprehensive school health education program to include dental health, disease control, environmental health, family life, mental health, nutrition, safety, and substance abuse, and that the National PTA reaffirm the 1970 position statement of the National PTA Board of Managers relating to Federal and State Support to Comprehensive School Health Education Programs while giving wide publicity to the similar position statement adopted by the . . . National Congress of Parents and Teachers, American Association of School Administrators, Council of State Boards of Education, National Education Association, and National School Boards Association . . . and be it further RESOLVED:

That the National PTA urge its state branches to cooperate with their state departments of education and health, and with local school districts, to develop such a program.

--Adopted by the 1973 Convention of the National Congress of Parents and Teachers.

Federal and State Support to Comprehensive School Health Education Programs (excerpt)

The National Congress of Parents and Teachers has consistently supported the inclusion of various health topics in the school curriculum. Resolutions and programs at both national and state levels have indicated PTA concern for alcohol and drug abuse education, smoking and health, physical fitness, mental health, family life and sex education, the need for continuous health supervision, consumer health, venereal disease education, nutrition, and accident prevention. Other health issues have received attention periodically through the years.

State laws and state board of education regulations (either permissive or mandatory) influence the nature of educational programs offered in schools. Some states have recently revised outmoded laws and regulations to meet current needs, including the provision of definite time in the curriculum and qualified leadership. Funding from governmental agencies at federal, state, and local levels also has great bearing on the quality of educational offerings. Often such funding has not included the subject-matter area of health as part of the instructional program.

The National Congress of Parents and Teachers supports the concept of comprehensive school health education programs and believes these programs should be given higher priority at national, state, and local levels. It urges educators to develop such programs and governmental agencies at all levels to provide the necessary funds. Further, it urges members of Congress, the Secretary of Health, Education and Welfare, the U.S. Commissioner of Education, state departments of education, and local school districts to establish higher priorities for these programs on a level comparable to other curricular subjects.

Suggested Policy Statement on School Health Education for State Boards of Education

Education Commission of the States (1982)

Introduction

The form that the partnership between health and education takes depends, in large part, on the leadership of state boards of education in their policy decisions. These policymakers play a crucial role, for they can influence not only the availability of school health education but also the nature of these programs in local school districts. The following policy statement has been developed to illustrate what state boards of education can do to affect the practice of school health education in their states. It reflects many of the ideas discussed in the task force's recommendations.

Because of the variations among state laws governing structures, economic conditions, and philosophies, it is impossible to develop a policy that will be meaningful and applicable in all states. However, it is hoped this model will illustrate some possibilities for action and stimulate discussion among state education policymakers.

Elements of a policy statement on school health education.

The following are suggested as major elements in a policy statement on school health education:

--Philosophical support for school health education
--Statement of leadership role
--Commitment of resources
--Delegation of responsibility to local districts to carry out state policy

--Recommendations to local districts concerning: planning and program development, staff, curriculum formation, and instructional time.

1. Suggested Policy Statement. It is the policy of the State Board of Education:

--To assure that all students in kindergarten through 12th grade are provided with learning experiences that will enable them to function effectively in the adult world. Comprehensive health education develops skills for daily living and prepares students for their future roles as parents and as citizens.

--To assure that efforts are made to emphasize health as a value in one's life, to enhance critical thinking, decision-making and problem-solving skills regarding health, and to motivate individuals to take an active role in protecting, maintaining and improving their health.

--To initiate appropriate procedures to stimulate and support local school systems in their efforts to design and implement instructional experiences in health education.

--To delegate to governing boards of each local education agency the responsibility for implementing state policy on school health education.

--To provide technical assistance through the state education agency to local education agencies in their efforts to plan, develop, evaluate, and improve health education programs in elementary and secondary schools.

2. Framework for Action. The state education agency shall provide leadership in comprehensive school health education by establishing the following structures, processes and resources. It shall provide for the

establishment of a state school health education advisory committee, the employment of at least one full-time qualified health education specialist to direct or coordinate the state school health education program, and for fiscal support for the development of local programs. The state board shall promulgate rules, regulations, guidelines and standards as necessary to implement this policy.

3.a. State level. Establishment of a State School Health Education Advisory Committee. A school health education advisory committee shall advise the chief state school officer and state board of education on major issues relating to the implementation of this policy. The functions of this committee shall be to: (1) communicate the definition, concept, and rationale of comprehensive school health education to specific groups identified as supporters, decision makers, providers, and consumers of comprehensive school health education; (2) assist in establishing a sound understanding and relationship among comprehensive school health education programs, school health services programs, and the public health, human services, and education programs of other agencies in the state; (3) participate in the development and conduct of a statewide needs assessment; (4) assist in the formulation of a five-year plan for the development of school health education at the state level; (5) share information about materials, programs and new resources of interest to school health education personnel; and (6) assist the director or coordinator of comprehensive school health education upon request.

If funds are available from federal and state sources, this committee may review applications of local education agencies and determine the eligibility of those agencies to receive funds. In determining eligibility, the committee shall take into consideration the extent to which districts have developed applications consistent with guidelines issued by the state education agency or other funding agencies.

The committee shall submit an annual report to the state board of education, the chief state school officer and legislature that includes a summary of accomplishments

and recommendations concerning implementation of comprehensive school health education.

3.b. Establishment of a Full-Time Specialist Within the State Education Agency. The board shall authorize the appointment within the state education agency of at least one full-time specialist trained and certified in school health education. This individual shall serve as the director or coordinator for comprehensive school health education and shall provide technical assistance to districts in establishing, developing and implementing health education programs in their schools. The duties and responsibilities of the director shall be: (1) to provide information on available curricula and resources, on existing exemplary health education programs, and on any guidelines or standards issued by the state education agency; (2) to advise local districts and district health coordinators in designing and implementing a planning process consistent with guidelines established herein; (3) to assist districts and district coordinators in the planning and development of inservice programs for teachers, administrators and other school personnel; (4) to serve as liaison to professional and community groups in the health and education fields; (5) to work on a cooperative basis with other state level officers and agencies, such as the school health education advisory committee, the department of health, divisions of inservice education, teacher certification, and higher education; (6) to provide information relevant to policy formation to state officials; (7) to plan and conduct a statewide needs assessment every five years; and (8) to develop and update annually a five-year plan for development of school health education programs at the local level.

The state director or coordinator for comprehensive school health education must have specialized training in health education and must participate in programs offering opportunities for professional growth since the director is the key person in program administration and facilitation.

4.a. Local level. Community/School Involvement. Local school boards should ensure that efforts to

establish a health education program include a planning process that involves parents, teachers, administrators, students, health professionals, and other community representatives. Mechanisms to solicit their input--such as a professional staff study committee, a community advisory committee, or a community/school committee--should be created and utilized. In addition to planning, these advisory bodies can play a continuing role in program development and implementation.

The local school board should oversee the formulation of a district policy, a statement of need, goals and objectives, and plans to develop and implement a program to address identified needs. The state director for comprehensive school health education shall provide information and assistance to districts in these various planning phases.

School health services personnel such as nurses and physicians, and other staff such as cafeteria workers, should be actively involved in the planning, development and implementation of a school health education program. In addition, staff from existing programs that have a strong relationship to the health of students (e.g., physical education, safety patrols, and driver education) should also be included in health education efforts and activities.

Whenever possible, health education for parents should be developed and conducted in the community.

4.b. District Coordinator. Each local board should appoint a qualified person to coordinate the planning and development of the school health education program. This individual should have professional preparation, experience, and interest in school health education. The district coordinator should provide leadership and opportunities for the involvement of all groups; organize the human and material resources necessary for program planning, development, and implementation; serve as a liaison with parents, community groups, health agencies, and health interest groups; provide for teacher training and inservice for other school personnel; and, assist in the development of evaluation mechanisms.

4.c. Teachers of Health. The most important element in making a quality health instruction program a reality are teachers who are interested and professionally prepared to teach health education. Local districts should hire teachers with appropriate preservice training in health education and train existing teachers by providing regular inservice and continuing education opportunities.

4.d. Curriculum Development. A planned sequential K-12 health education program should include but need not be limited to content in the following areas:

Personal Health
Mental and Emotional Health
Prevention and Control of Disease
Nutrition
Substance Use and Abuse
Accident Prevention and Safety
Community Health
Consumer Health
Environmental Health
Family Life Education

4.e. Instructional Time. In grades K-6, health education should be integrated into the formal instruction program. In addition, special attention should be given to opportunities for incidental health instruction when appropriate situations arise during the school day.

During the middle school or junior high school years the minimal time allocation shall not be less than one semester or its equivalent. One semester is required during the senior high school experience. Health education at this level should be in the form of direct instruction, but should be supplemented by correlation, integration, and incidental teaching.

School districts should have a plan which will ensure that the content areas defined in the school health education policy are being adequately taught. The plan should be written, with specific objectives and curriculum outlines for each grade level.

APPENDIX B

COMPREHENSIVE SCHOOL HEALTH EDUCATION: AN OPERATIONAL DEFINITION
Association for the Advancement of Health Education (AAHE) (1980)

Throughout our nation, those associated with improving health education in schools are being more and more frequently asked: "What is comprehensive school health education?" "What does comprehensive mean?" "What does a comprehensive program include?" "Can you describe a model that we could use to understand it better?" "How can we structure our program to ensure that it can be comprehensive and effective?" The people asking these questions include representatives of concerned parent and community groups, staff of health planning bodies, school board members, professional and voluntary health organization staff, education administrators, legislators and government officials.

Officials in the U.S. Office of Health Information and Health Promotion (OHIHP), assigned to develop governmental policies for health promotion, requested staff of the School Health Education Project to facilitate the generation of a definition of comprehensive school health education by health education professionals. Staff time for the generation of the definition was provided by the U.S. Bureau of Health Education (BHE) under the terms of its school health education contract with the National Center for Health Education.

A working document was prepared by staff of the School Health Education Project to provide information about issues of importance in defining comprehensive school health education. Within the working document, recommendations about the following elements of

comprehensive programs are proposed for analysis: (a) goals and objectives; (b) content; (c) resources; (d) evaluation; and, (e) management. Collectively, the finalized recommendations might serve to provide an operational definition or guidelines for those requiring information about the components of comprehensive school health education.

In cooperation with the U.S. Office of Comprehensive School Health, OHIHP, and BHE, delegates of agencies represented by the Coalition of National Health Organizations have been requested to review and amend the working document. Pending agreement by delegates to the Coalition, and then by the organizations which the delegates represent, each agency might move to accept responsibility for and endorse the definition developed. This definition could thus be made available in various formats to those responsible for decisions which influence health education in our nation's schools . . . .

The recommendations which have been proposed for analysis within the working document are as follows:

(A) Goals and Objectives

Recommendation No. 1: Comprehensive school health education programs should include clearly stated goals and objectives, the attainment of which should logically result from prescribed program activities, and the attainment of which is valuable.

Recommendation No. 2: The paramount goal of school health education should be to enhance the competencies of individuals to make decisions regarding their personal and family health, and the health of the populations of which they are a part. School health education programs can effectively contribute to enhancing health behaviors and the health status of the population acording to the extent to which they function in concert with specific school and community health promotion activities which enable and reinforce targeted health behaviors.

Recommendation No. 3: Comprehensive health education programs should be designed to address multiple categories

of objectives. In addition to enhancing cognitive skills, programs should facilitate the development of relevant affective abilities including personal, interpersonal, extrapersonal, and specific health skills. Programs should also be designed to improve psychomotor skills that are health-related.

(B) Content

Recommendation No. 4: Each educational service provider should select and present that health education content which, consistent with the specific needs and wishes of its constituency, would address the most important health concerns of its service population. In order systematically to apply the resources of public education toward meeting national health goals, at least the following content areas should be included: smoking; nutrition; alcohol abuse; driving (safety); exercise; human sexuality and contraceptive use; family development; risk management; and stress management/coping/enhanced self-esteem. In addition to addressing the prevention of discernible health problems, content should be selected to address the evocation of high levels of physical and mental wellness.

Recommendation No. 5: Learning experiences and health content should be selected to enable children at each age or grade to master those health-maintenance skills necessary to cope with specific potential threats to their health in the coming age or grade, and those additional foundation skills necessary to benefit from the instruction next year in relation to the specific potential health problems of the year after that. In the early primary grades, health education programs should primarily focus on the health problems and behavioral situations that children will face in the near future. In the middle grades, health education programs should address health problems to be encountered in the next several years. In the secondary schools, health education should be directed increasingly toward health problems of the more and more distant future. However, even in the

primary grades the health problems addressed should include those not clinically manifest until adulthood.

(C) Resources

Recommendation No. 6: Comprehensive school health education should be sufficiently supported to provide: appropriate teaching materials and resources; a coordinated sequential program of direct health education for all students enrolled in pre-school through grade twelve; and teachers professionally qualified via completion of preservice or inservice training in school health education, and by virtue of their sincere interest in teaching health education.

(D) Evaluation

Recommendation No. 7: Comprehensive school health education programs should include evaluation activities designed to provide information about the appropriateness and the effectiveness of instructional organization, materials, and practices formulated to enhance the competencies of students to make health-related decisions. In addition, evaluation activities should provide planning information about the comparative needs, status and progress of individuals and groups. The responsibility for evaluation of the contribution of school health education programs to behavioral and health outcomes should be jointly shared by the health and education professions.

(E) Management

Recommendation No. 8: Comprehensive school health education programs should include identifiable resources, policies, plans and procedures for the effective and efficient management of related activities at state, regional, and local levels. Administrative support and administrative responsibility for the program should be established at each level.

APPENDIX C

TEACHER CERTIFICATION FOR HEALTH EDUCATION:
A POSITION PAPER
Association for the Advancement of Health
Education (AAHE)

Statement

School health education is a fundamental and indispensable component of basic education. As such, teachers who work in this area should be certified in health education. The Association for the Advancement of Health Education strongly supports the need for certified teachers in health education.

Historical Background

Since the beginning of education in the United States, health education has been identified as a priority. Horace Mann, Lemuel Shattuck and other individuals as early as the mid-1800s indicated its importance as an instructional area in education. Authoritative groups such as the American Medical Association, the National Parent Teachers' Association, the National Education Association and the American Academy of Pediatrics have endorsed the significance of health education in the schools of the nation.

More recently, recognition of the importance of school health education has been expressed through legislative action. Thirty-six states currently require by law a separate certification for health education teachers.

A commitment to health education at the national level was made with the establishment of the Office of Comprehensive School Health and the Bureau of Health Education in the Public Health Service. Concurrently, the National Center for Health Education, which represents a commitment in the private sector, was established in San Francisco. Health education was also one of the ten state priorities in the National Health Planning and Resource Development Act.

Rationale

There is little doubt that the rapidly increasing cost of health delivery in the United States can be largely attributed to the major emphasis on treatment and tertiary care. Health professionals agree that primary or preventative care represents the most effective answer--economically and in terms of better health for all Americans.

Health education is a fundamental ingredient in the prevention formula. It can facilitate a personal and community responsibility for the prevention of disease and disability and the promotion of well-being. Most causes of premature death and infirmity can be prevented by positive health practices and appropriate health care.

Public health education is a significant factor in achieving and maintaining sound health. The schools, however, are the institutions designed to provide young people with the intellectual basis and necessary skills to achieve individual aspirations and to effectively cope in modern society. It is vital that the educational enterprise devote attention to providing basic health knowledge and skills which serve as a prerequisite for functional decision-making and action. This necessitates a strong pedagogic and content foundation in the discipline. Thus, it is essential that teachers with professional preparation in health education should perform the function of health instruction in the schools.

Professional health education background should include work in program organization, teaching strategies, materials and resources, health need and interest assessment, evaluation and specific internship

experiences. Content competencies should be acquired in such areas as drug use and abuse, human sexuality, consumer health, nutrition, anatomy and physiology, community health, first aid, emotional health and disease control.

For the elementary school teacher, preparation in health education should be included as part of the diversified major. For the secondary school teacher, where specific subject-matter concentrations are generally designated, a major in health education should be required for those desiring to teach in that area. Certification, separate from other academic areas, should be a requirement.

Recommendation

It is reasonable to expect that teachers of health education should meet requirements comparable to those in other areas of instruction. The Association for the Advancement of Health Education endorses a separate certification in health education which leads to the attainment of basic competencies in the discipline.

It is recommended that:

1. Each state department of education recognize health education as a separate academic subject by its inclusion in the curriculum.
2. All states require certification in health education for teachers of the subject in secondary schools.
3. In-service education programs in health education be provided to respective school districts to supplement and update the knowledge of teachers currently teaching health.
4. Student-teaching experiences in health education be included as a requirement of certification in the field.

5. The results of the Role Delineation Project of the National Center for Health Education be utilized by professional preparation institutions, along with other certification standards, to help assure quality programs for teacher education.
6. All states require preparation in health education for certification of elementary teachers.

ABOUT ERIC

ERIC, the Educational Resources Information Center, is a nationwide dissemination system of the National Institute of Education, U.S. Department of Education. Through a network of 16 clearinghouses, ERIC collects, evaluates, abstracts, and indexes all kinds of educational literature, much of which is unavailable from other sources. Document literature includes project reports, conference speeches, curricular guides, instructional materials, and many other nonjournal articles. ERIC also indexes more than 700 educational journals. For information about ERIC, readers should consult the monthly ERIC periodicals, Resources in Education (RIE) and Current Index to Journals in Education (CIJE). These may be found at many college and university libraries along with the ERIC microfiche collection of documents.

Readers are invited and encouraged to comment on this monograph and to submit related documents to the Clearinghouse for possible inclusion in the ERIC system. For information, write the Senior Information Analyst, ERIC Clearinghouse on Teacher Education, One Dupont Circle, Suite 610, Washington, DC 20036, or call (202) 293-2450.